

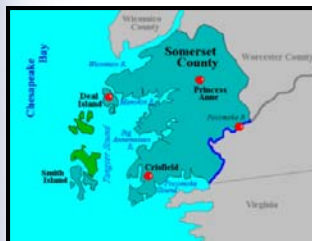
Somerset County Health Department

1422 Grant Site Visit

Crystal Bell, MPA



DEMOGRAPHIC OVERVIEW



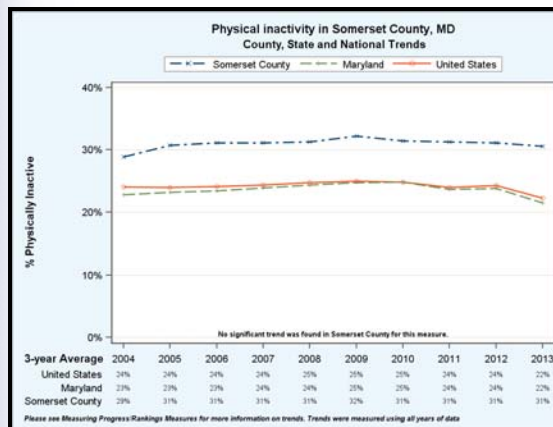
- Somerset County is located on the Eastern Shore of Maryland
- Population is 25,768
- 54% White
- 42.4% Black or African American
- 3.5% Hispanic and 2.1% two or more races
- Somerset County has the highest rate of poverty in the state, with 25.5% living below the poverty line and a per capita income of \$16,748 (2015 *United States Census Bureau*).

CHRONIC DISEASE BURDENS

Health Statistics	Somerset	Maryland	County Ranking
Overall Mortality / 100,000 Population (Age-Adjusted)	946.6	793.5	2
Heart Disease Mortality / 100,000 Population (Age-Adjusted)	285.5	181.6	1
Diabetes Mortality / 100,000 Population (Age-Adjusted)	(U)	20.4	(U)
Rate of Obesity	37.22%	27.61%	2
Rate of Diabetes	23.58%	10.39%	1

Source: 2015 Census Data

HEALTH RISK FACTORS



1422 GRANT OBJECTIVES

- Strategies to build support for lifestyle change for those at high risk of chronic disease health burdens
- Environmental strategies to promote health and reinforce behaviors
- Health System Interventions to improve quality of healthcare delivery to high priority population
- Build community linkage strategies to support 1422 prevention efforts

INTRO TO 1422 GRANT

- Initial Meeting With (LHIC) April 14, 2015
- Health risk factors reviewed
- County goals/objectives identified



KEY PARTNERS

- McCready Health
- Peninsula Regional Medical Center
- Chesapeake Healthcare (FQHC)
- Somerset Recreation and Parks
- Crisfield Clinic
- Marion Pharmacy
- Crisfield Pharmacy



BUILDING SUPPORT OF NDPP

- Face-to-face office visits
- Effective communication/Continued support
- Clear and concise understanding of NDPP



BUILDING SUPPORT OF NDPP **(CONT.)**

- Raising awareness (marketing/outreach)
- Quarterly report updates/progress reports
- Creation of Bi-directional referral system
- Patient follow up letters
- Effective program results
- Positive feedback

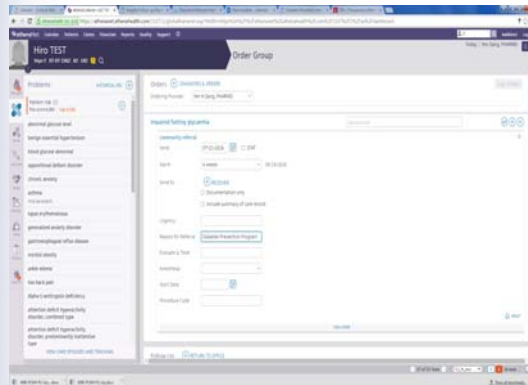
**IT'S ALL ABOUT TRUST
&
COMMUNICATION!**

Health System Interventions

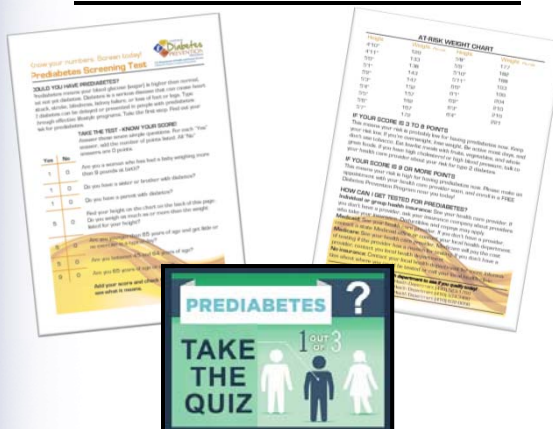
- Patients with risk factors for developing diabetes (A1c, family history, history of gestational diabetes, etc.—are flagged in the EHR system)
- Patients that have been identified are screened at their office visit using the tools LHD's provided (CDC Risk Scorecard)
- Nurse or provider gives the patient information (flyers, brochures, or website printouts) that highlight corresponding county DPP program information
- If the patient agrees, FQHC has patient sign a HIPPA release and referral is sent through EHR to the appropriate county w/provider signature



DEVELOPING AND IMPLEMENTING NDPP SYSTEMS



RESOURCES/MATERIALS





Resources/Materials

SOMERSET COUNTY

Diabetes Prevention Program

- Designed to help individuals learn how to eat healthier, move more, and lose 5-7% of body weight.
- Includes weekly physical activity sessions and a personal Lifestyle Coach.
- Taught by Centers for Disease Control (CDC) trained Lifestyle Coaches.
- Program can be brought to your worksite, faith-based organization or community site.
- 16-week program with 6 months of follow-up sessions.





For more information or to register for an upcoming program, call your Local Health Department today!


Public Health
Somerset County
Department of Health
443-523-1760
www.somersethealth.org

Like us on Facebook!

This publication was made possible with funding from the Centers for Disease Control and Prevention through the National Department of Health and Human Services Center for Chronic Disease Prevention and Control.

SOMERSET COUNTY

Diabetes Prevention Program



- Eat Better
- Move More
- Live Well

Public Health

Resources/Materials



Eat Better. Move More. Live Well.

TEXT "RISK" TO 97779

Prevention at your fingertips
DoIHaveDiabetes.org

Funding made possible by Somerset County, Somerset Township & Township of Bridgeton. © 2010 Somerset County, Somerset Township & Township of Bridgeton.

Lower Your Risk. Know Your Numbers.



DOIHAVEPREDIABETES.org

RESOURCES/MATERIALS

[illegible]

PARTNERSHIP AND SUPPORT

- **SCHD worked closely with community partners**
- **Ensured all efforts aligned with 1422 and county objectives**
- **Will continue partnerships and support for other collaborative programs**



CHALLENGES

- Expanding/Sustaining NDPP within County
- Limited resources/venues
- Increased referrals from (TLCCS)
- Engagement of community to support lifestyle change programs
- Raising awareness about prediabetes among community stakeholders
- Pay for performance reimbursement model

SUCCESSSES

- Development of bi-directional referral process between community resources and health systems
- Implementation of (6) DPP classes within county
- Development of effective continued communication methods to recruit and support DPP
- Increased worksite wellness initiatives
- DPP program/participant success of 7% weight loss
- Increased physical activity opportunities

QUESTIONS?

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Thank you!